CAP-MR/DD WAIVER
QUESTION AND ANSWER
December 30, 2005

TOPIC	QUESTION	RESPONSE
Supported Employment	Under Supported Employment, the CAP Manual states that "Documentation will be maintained in the file of each individual receiving this service that states: *The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142."* How is this to be decided and documented?	The unavailability of VR funding must be documented in each instance. If a person does not have a job, the person should be referred to VR for a determination of VR eligibility or ineligibility. If VR determines that the person is not eligible or will not provide services to the person, obtain a letter to that effect for the client record. If the person is VR eligible but VR cannot serve the person right away (due to order of selection limitations), obtain a letter from VR stating that the person cannot be served in the near term. This enables a finding that VR funding is not available. If the person already has a job, it is not necessary to refer to VR because VR does not fund follow-along supports and thus VR funding is not available. In that instance, include a finding to that effect in the case record. The requirement that is in the Core Services definition is long-standing and is based on Medicaid statute. If a person is receiving VR services, Medicaid can still pay for S/E services that VR does not cover.

CAP-MR/DD WAIVER
QUESTION AND ANSWER
December 30, 2005

Home and Community Supports	If a Consumer needs Home and Community Supports (HCS) and Personal Care (PC) how is that to be blended? What if they need PC in the morning and in the evening but HCS during the day? Can it be worked intermittently like this or does it have to be worked in one large block of time for each service?	How much PC is provided vs. HCS is provided, and when it is provided, is based on the person centered plan. There are no requirements that either occur in any specific block of time. It should be based on the type of needs and outcomes expected...for example, if the person really just needs assistance with personal care tasks, then the focus will be on PC. However, if they are out in the community or learning independent living skills in the home, the focus would be on the hab associated with HCS...there is also some support and supervision within HCS which can provide support to meet some incidental personal care or support that could occur without having to move in and out of PC.
Endorsement of CAP Services	Should implementation reviews continue until endorsement window for CAP?	Yes.
Home and Community Supports/Day Supports	Can an individual in a licensed residential setting or unlicensed AFL setting receive HCS and Day Supports?	No. Individuals in licensed residential settings or unlicensed AFLs should not be receiving HCS AND Day Supports. They will either be attending a licensed day facility or have a structured day program using the community component of HCS. Use of HCS for individuals residing in licensed settings or unlicensed will be monitored closely. Outcomes that should be provided by the residential provider should be denied as HCS. Going to the mall and

		shopping are not acceptable day activities when HCS is being used to meet day program needs.
Personal Emergency Response System	Is Personal Emergency Response System arranged and billed through the LME?	This service must be coordinated and billed through a licensed Personal Emergency Response System agency enrolled to provide the service. These agencies have trained staff to respond.
Third Level Reviews	New Process of Review for Plans over $85,000	For a Plan of Care over $85,000 that has been through a first and second level of review locally and has been denied, it is no longer required to send it to the Division for a third level review. However, if it has been through a first and second level review and is approved, it must then be sent to the Division for a third level review.
Coordination of CAP-MR/DD with other CAP programs	Will Cap/C services have to end on the date a MR2 is approved for Cap/MR? What services can a consumer receive during the transition period?	Should an individual require a different level of care and need to be referred to another CAP Program, the coordination of the transfer needs to be made in conjunction with the other CAP program. This requires careful planning since the date of MR2 approval any other CAP program would be discontinued. Both the sending and receiving cmgrs need to keep each other informed of the status of the transfer and provide the terminating CAP sufficient notice of approval for termination from the original program. A person cannot receive services from two CAP programs at the same time.

CAP-MR/DD WAIVER
QUESTION AND ANSWER
December 30, 2005

Specialized Equipment and Supplies	If an item has gone through CSHS and CSHS has denied it based on medical necessity, may it then be approved under the waiver?	No. The equipment should then not be approved through the waiver. If it is denied based on medical necessity then that decision stands.
Termination	Must an individual be terminated from the waiver if services are not provided for 30 days?	Basic CMS policy is that for an individual to be considered to require the level of care specified for the waiver, it must be determined that a person requires at least one waiver service, and requires the provision of waiver services at least monthly, or if less frequently, requires monthly monitoring to assure health and safety. Individuals may not be enrolled in the waiver for the sole purpose of enabling them to obtain Medicaid eligibility. The person must receive at least monitoring through case management to insure health and safety on a monthly basis. If waiver services continue not to be used, discussions should occur as to whether the waiver is appropriate to meet the needs of the individual.